The NASW Standards of Practice on Ethics strongly emphasize that clients have a right to self-determination.

In a medical setting self-determination might include:
- The right to accept or refuse various treatments.
- The right to ask questions about treatments, and to receive understandable answers.
The right to initiate a Living Will, or Advanced Directive, indicating which interventions one does, and does not, want under various conditions.

The right to have a Living Will honored.

Most clients we serve have family members and friends that have certain rights and needs. These might include:

- The right to disagree with decisions that their medically ill loved one may make.
- The right to ask questions and receive understandable answers.
- The right to disagree with other family members and friends.
• Physicians, Nurses, Social Workers, and other Healthcare staff may have strong feelings and beliefs about medical care and the decisions people make.

• NASW Standards of Practice encourage Social Workers to seek consultation and supervision when they feel they may lose objectivity.
  ◦ It is important to remember that other Healthcare staff may have less emphasis on self-awareness and the need for consultation.

• Value conflicts arise between clients, family, friends, and medical providers.
  ◦ Conflicts can occur in situations where difficult decisions may need to be made quickly.
  ◦ Conflicts may also occur when emotions and stress are increased.

• What should the Social Workers role be when these value conflicts occur?
Case #1

- Mr. A comes to VA from a community hospital because he had a stroke and suffered anoxic brain injury during cardiac arrest. He is sedated and intubated (has a breathing tube and cannot breath without it). He is age 75 and does have a Living Will that states he does not want to be kept alive by artificial means if Physicians think he cannot recover. He named his cousin Ms. B as his surrogate decision-maker on the Living Will and also named his cousin Mr. C as the second surrogate if Ms. B should be unable to make decisions. Both cousins live about 3 hours from the VA.

- Physicians determine that Mr. A will never be able to breathe on his own or recognize people or care for himself.
- The Social Worker attempts to reach Ms. B by phone and finds a full voicemail box. This continues for several days.
- Another cousin, Ms. D calls and talks to the Social Worker and expresses concern about Mr. A being allowed to die with dignity. Ms. D is very upset and calls almost daily, but she is not listed on the Living Will as a decision-maker.
• Ms. D also tells the Social Worker that Ms. B wants Mr. A kept alive so she can continue to get his check.
• Ms. D continues to call frequently and Ms. B continues to be unavailable by phone.
• Ms. B comes to the hospital to see Mr. A and thinks he recognizes her and thinks he will get better and tells the staff to continue to keep him alive.

• Medical staff express frustration to the Social Worker and want to know if they can move on and have Mr. C be the decider, or better yet Ms. D.
• An Ethics Consult is called and VA Attorneys say that Ms. B is still the designated decision-maker.
• Mr. A continues to be in his hospital bed, unresponsive and on the ventilator.
Discussion Questions:

- If you were the Social Worker assigned to Mr. A and his family, what actions would you take?
- How would you respond to the frequent calls from Ms. D?
- How would you respond to the frustrations of the medical staff?
- What feeling and personal beliefs come up for you in this case? Would you seek supervision or consultation?

- What are the conflicting values?
- Who will be effected by any decisions that are made?
- What are some possible courses of action?
- What are the risks and benefits for each course of action?
• Do you think that Mr. A’s Living Will was honored?
• If you think it was not honored, would you make a statement about it in the Ethics discussion with the VA Attorneys?

Case #2

• Mr. V is a 62 year old, married but separated Veteran who is currently living alone. He has a history of Alcohol Dependence, PTSD, high blood pressure, and diabetes. He is unemployed and has limited resources. There is no running water in his home, though his wife states that he does come to her home from time to time, and she will assist in helping him to get cleaned up.
His neighbors became worried after a few days of no contact, and they then called 911. Paramedics found him lying in the floor, in his own feces and urine, amongst many beer cans. Once he was admitted into the hospital, it was determined that he had suffered a stroke which left his speech impaired and communication difficult. He also was diagnosed with congestive heart failure. This too made it difficult for him to talk due to fluid buildup in lungs and difficulty breathing. Mr. V does have an Advance Directive. His surrogate, Ms. X is a female who has no relation to him.

Current wife, Mrs. V and Mr. V's sister have discussed with ICU staff that they want the Advance Directive changed.

Â Both repeatedly express to the ICU staff their disdain about Ms. X being the surrogate.
Â According to the staff, Mrs. V and Mr. V's sister report that Ms. X should not be the surrogate and that she has “caused issues within Mr. and Mrs. V's marriage” and because “Mrs. V is his current spouse.”
Â Staff are asking the Social Work Intern to assist in making this change.
Â The Social Work Intern explain that only Mr. V is able to make any changes to his Advance Directive.
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Discussion Questions:

• How would you educate the R.N. while still helping her to process her own feelings about the case?
• How would you respond to the Veteran’s wife and sister and their concerns?
• What feeling and personal beliefs come up for you in this case?
• Would you seek supervision or consultation?
Case #3

- Mr. Jones is a 64 year old Caucasian male with a diagnosis of Mood Disorder, Depression, History of Alcohol Abuse/Polysubstance Abuse and a history of HI/SI. Mr. Jones has had frequent admissions to the hospital for ETOH detox for many years. He has left-sided hemiparesis secondary to a gunshot wound in 1992 (not sustained during the military). Patient uses a motorized scooter and a wheelchair to ambulate and can walk some with difficulty. Patient is able to do transfers (bed to chair, chair to toilet, etc.) but does require assistance with some ADL’s.

- Per Psychiatry patient has capacity to make his own decisions but continues to make poor choices by drinking, doing drugs and then being brought to the VA’s ED for detox.
- Patient reports that he wants to live in the community but MD feels he needs placement.
- Patient states he would rather die in the streets than go to a nursing home or assisted living facility.
- Patient has been placed several times by SWS but either leaves AMA or is asked to leave/evicted for breaking the rules, public intoxication, polysubstance abuse and inappropriate behaviors. Even the homeless shelters are now refusing to admit him.
• Patient does not cooperate with plan of care by refusing all options available: homeless shelters, residential care, assisted living, nursing home, etc. He sabotages any plans that are made to get him back in the community.

• Patient refuses to be placed in any setting that requires him to pay or lose his income.

• Patient shows insight at times about his situation, but continues to make choices which involve alcohol and drug use, which eventually results in him returning to the ED.

• Medical Staff express frustration over the difficulty finding placement for patient.

• SWS continues to try and locate a placement for the patient. Patient was discharged to a homeless shelter. He was brought back to the ED by his VA Case Manager within a few hours of discharge. Patient was not admitted immediately, but was eventually admitted after being found the next afternoon intoxicated on the VA campus. The patient threatened VA Police Officers and was brought to the ED in handcuffs.
Patient has managed to bring his D/C plan to a standstill. The Medical Team keeps documenting that patient is waiting on placement even though Social Work has thoroughly documented that veteran refuses to accept placement and has burned his bridges to the community resources. Psychiatry continues to say that patient has decision-making capacity.

Discussion Questions:

- What can be done to break this cycle?
- Is Psychiatry correct that veteran has capacity?
- Is Medicine enabling this patient?
- Should charges be made against the veteran?
- What are the patient’s rights?
- Could this case be submitted to the Ethics Committee?
What should the Ethics Committee do?
Should the fact that the hospital pays for this veteran to get better when he is so non-compliant be a factor? Should the hospital detox the veteran and immediately discharge back to the streets?
Is Social Work overlooking options in the community for this patient?

Case #4

Mr. Smith was a 34 year old Caucasian male admitted to the hospital for complications due to multi organ failure and cirrhosis of the liver. He also came to the VA thinking he was being evaluated for a liver transplant. He was not a candidate and was given this information, but still believed if his health improved, he would be given a new liver. Mr. Smith did not have an Advance Directive or any documents stating his wishes regarding end of life planning.
The patient’s condition began to worsen, he was informed of his prognosis.

No next of kin were present when we began to work with him.

Talked to him about Advanced Directives, but he stated he wanted to wait until his father arrived from out of state to have that conversation.

Doctors began to push for him to have an Advanced Directive.

The last two times we addressed it with Mr. Smith, he became upset and tearful.

Mr. Smith was in denial about his prognosis, he believed his health was going to improve.

Following the last conversation about Advanced Directives, we decided to back off.

Mr. Smith passed away almost exactly one month following his admission to the hospital.

Shortly before his passing, his father arrived at the VA and he completed an Advance Directive.

His final wishes were carried out as he outlined in his Advance Directive.
Discussion Questions:

• What are some ways that you would work with the Doctors and other medical staff when they are pushing for the Social Workers to work with the patient to complete an Advance Directive, but the patient is not willing to do so?

• How would you approach a patient/client about completing an Advance Directive, or other paper work, when they are against it?